Patient's Name:_____ Date of Birth:_____
*Last* *First* *Initial*

I am being provided with this information and consent form so that I may better understand the treatment recommended for me. Before making a treatment decision, I wish to be provided with sufficient information, in a form that I can understand, in order to make a well-informed decision regarding my proposed treatment.

I understand that I may ask any questions I wish, and that it is better to ask questions prior to treatment than to raise issues about it after treatment has started.

Full denture restorations replace your missing teeth. They are not fixed in place, and they are removed from the mouth for cleaning. They differ from restorations that are supported and/or retained by natural teeth or dental implants in as much as they are supported by your gum tissue and remaining jaw bone (alveolar bone). Full dentures are stabilized and retained in place by intimate (close) fit with your gum tissue and by other oral tissues (cheeks, lips, and the tongue). Learning to speak and chew with a full denture requires learning how to manage and control the restoration with your tongue and other mouth muscles. Controlling a denture when speaking and chewing will improve with time and experience.

Full denture restorations typically require a number of visits to complete treatment. An impression, or mold, of the top mouth tissues is made using a rubbery material or may Digital Scan. A trial denture is created for cosmetic approval, and the final denture restoration is then produced by a dental laboratory. It is important to return for the insertion of the final restoration as soon as it is ready. The full denture restoration is one option for treatment and is based upon visual examination(s), on any X-rays, models, photos and other diagnostic tests taken, and on my medical and dental history. My needs and desires also have been considered.

The prognosis, or likelihood of success, of this procedure is _____. However, I understand that no guarantee, warranty, or assurance has been given to me that this treatment will be successful, or for how long.

My full denture(s) is (are) estimated to cost $ _____ and estimated to take_____ visit(s) to complete over a period over a period of _____ weeks/months.

## Alternatives to Full Denture Restoration

Depending on the condition of my mouth and my current diagnosis, there may be other treatment alternatives to a full denture restoration. I understand that possible alternatives to a full denture in my case may be:

- **Replacement of a missing tooth or teeth by a tooth-supported fixed bridge.** If my remaining natural teeth are sufficiently stable and strong, a tooth-supported bridge may be possible. A bridge is cemented in place and is not removable. This procedure requires drilling natural teeth to properly shape them to support the fixed bridge.
- **Replacement of teeth with a fixed or removable implant restoration.** Dental implants permit missing teeth to be replaced by the use of crowns, bridges and dentures (known as "overdentures") that are supported or retained by attaching to the implant(s). It has been recommended that I consider one or more implant restoration(s):
  ___Single crown on implant in the position of tooth (or teeth) # _____
  ___Fixed bridge on implants in the position of teeth # _____
  ___Implant-retained removable partial denture(s) replacing teeth # _____
  ___Implant-retained full denture(s)/overdenture(s) replacing all teeth, using **[ #/position ]** implants for stability/retention.
  ___Other:_____

*continued…*

- **No treatment.** I may decide not to replace the missing tooth or teeth. If I decide upon no treatment, my teeth may shift over time, causing chewing or gum problems. Dental decay and or gum problems (periodontal diseases) may lead to pain and infection, which may become severe.

_____ I have had an opportunity to ask questions about these alternatives and any other treatments I have heard or thought about, including _____.
*Patient's Initials*

## Risks of Full Denture Restoration

I have been informed and fully understand that there are certain inherent and potential risks associated with full denture restorations. I understand that during, and for several days following treatment, I may experience stiff and sore jaws from keeping my mouth open. I understand that I may experience pain, discomfort or infection with extractions. I understand that a denture restoration may not relieve my symptoms or meet my expectations for comfort, function, or esthetics. If I select full denture treatment with no dental implants, I understand that retention and stability may be compromised, although the full denture fits my gums closely. Stability and retention will be further compromised if the amount and/or quality of my remaining jaw bone is limited. Sore spots under a full denture are common, especially for a new denture. I understand that the denture may require adjustments soon after delivery, and periodically, in order to relieve pressure spots and to stabilize the bite (occlusion).

I understand that my saliva flow may increase, especially right after I start using full dentures. I understand that I may notice changes in my bite compared to natural teeth or previous restorations, and that dentures will not provide the same chewing strength or efficiency of natural teeth. I understand that my gums and jaw bone will recede (shrink) over time. As a result, the full denture(s) must be relined periodically to re-fit the denture to my mouth. I understand that a new denture may be necessary, rather than a reline, if my gums and jaw bone shrink significantly. I understand that dentures are made using a strong plastic material. Nevertheless, the material is susceptible to breakage, especially if dropped. Most denture cracks/breaks can be repaired, but not all. The plastic also will weaken over time and may require replacement instead of repair.

I understand that I may be able to have dental implants placed later to help stabilize and retain my denture(s). However, bone grafts or other procedures may be required for implants and overdenture treatment to be successful. Placement of implants later also may require new full denture restoration(s) if the existing denture(s) cannot be effectively modified to attach to the implants. I understand that poor eating habits, poor oral habits (smoking or chewing tobacco, fingernail biting, etc.), poor oral hygiene, and certain medical conditions or medicines will negatively affect how long my full denture restoration lasts.
[IF NEEDED] I understand that I may be given a topical anesthetic and/or local anesthetic injection. Although rare, it is possible that patients may have an allergic reaction to these medications. Adverse reactions to anesthetic medications are possible, such as lightheadedness, dizziness or drowsiness. Please contact [Dr._____/the office] if numbness remains more than a few hours or if you develop a rash. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from the anesthetic injection. I also understand that temporary or permanent injury to nerves and/or blood vessels from the injection may occur. Nerve disturbances may include pain or numbness, and/or unusual sensations such as itching, burning, or tingling of the lip, tongue, chin, teeth, and/or mouth tissues.
Other foreseeable risks not stated above include: _____.

_____ I have had an opportunity to ask questions about these risks and any other risks I have heard or thought about, including _____.
*Patient's Initials*

*continued…*

## Acknowledgment

I have provided as accurate and complete of a medical and personal history as possible, including medications I am currently taking (antibiotics, pain drugs, or other medications, including non-prescription medicines, herbs or supplements) and materials or medicines to which I am allergic. I will follow any and all treatment and post-treatment instructions as directed and explained to me and will permit the recommended diagnostic procedures, including X-rays.

I realize that, in spite of the possible complications and risks, my recommended treatment is necessary. I am aware that the practice of dentistry is not an exact science, and I acknowledge that no guarantees, warranties, representations or assurances have been made to me concerning the results of the procedure.

I,_____, have received information about the proposed treatment, as well as the risks associated with refusing treatment. I have discussed my treatment with Dr._____and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, the risks of the recommended treatment, and the risks of refusing treatment.

I wish to proceed with the full denture treatment **[ with / without implants ].**

**I wish to proceed with the recommended treatment.**

_____ I understand this treatment can also be performed by a prosthodontist (dental restoration specialist).
*Patient's Initials*

_____ I understand the risks associated with this treatment and elect to have this procedure performed by Dr._____. I understand that if any unexpected difficulties occur during treatment, I may be referred to a prosthodontist for further restorative care.
*Patient's Initials*

Signed:_____ Date:_____
*Patient or Guardian*

Signed:_____ Date:_____
*Treating Dentist*

Signed:_____ Date:_____
*Witness*